ARIZONA MEDICAL BOARD
9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258
Home Page: http://www.azmd.gov

Telephone (480) 551-2700 • Fax (480) 551-2704 • In-State Toll Free (877) 255-2212

APPLICATION for LICENSE to PRACTICE ALLOPATHIC MEDICINE
in the STATE of ARIZONA

ALL FORMS PROVIDED MUST BE COMPLETED BY THE APPROPRIATE ENTITY AND RETURNED DIRECTLY TO THIS BOARD

INFORMATION

Please see the requirements for licensure under the Arizona Revised Statutes and Rules prior to applying for licensure in Arizona. They are available at www.azmd.gov. For your convenience, we have attached a copy of the Arizona Revised Statutes regarding the requirements for licensure. All fees are non-refundable. Should you apply for licensure and not meet the requirements as per Arizona Revised Statutes and Rules, you may be denied licensure. Applications not fully complete within one year from date of notification of deficiency in application are considered withdrawn. All correspondence/documents must be addressed to the Arizona Medical Board.

APPLICATION INSTRUCTIONS

(Read Carefully)

In addition to the appropriate completion of the applicable sections of this application, the applicant will submit the following:

Evidence of name and date of birth: a copy of birth certificate or other documentary evidence for consideration, i.e., visa, passport, baptismal certificate, alien resident card or naturalization certificate. (Do not submit originals.)
Evidence of any legal name changes other than that shown on certificates filed in accordance with paragraph 1 above, i.e., marriage license or official name change through the court.
A complete list of all your hospital affiliations and medical employment for the five years prior to filing this application.
Home address, telephone number, social security number and date of birth.
Check, Money Order or Payment Authorization in U.S. Funds covering the statutory application fee prescribed in statute and rule ($500). This fee is for processing your application only. Should your application be approved you will be invoiced a prorated licensing fee.
Survey Form.

- **Credentials submitted in foreign languages shall have affixed thereto a certified translation into English.**
- **Requests for exemptions or waivers of any portion of this application will be denied and will delay your consideration for licensure.**
- **All credentials submitted become the property of the Arizona Medical Board and *will not* be returned.**
- **Photocopies shall not exceed 8 ½ inches by 11 inches in size.**
- **If paying by Payment Card Authorization, the application and documents may be faxed to 480-551-2704.**

Please Note: The Arizona Medical Board now accepts Federation Credentials Verification Service (FCVS) documents that are received by the Board directly from the Federation of State Medical Boards (FSMB) as primary source verifications. Contact the Federation at http://www.fsmb.org if you need more information regarding this service. If you are using FCVS you will not need to supply the Board with the following items, as they are included in the FCVS packet:

a) Medical School Verification
b) Postgraduate Training Verification
c) ECFMG Certification
d) Licensing Examination Scores (if United States Examination)
e) Birth Certificate

These items will be identified on the application checklist in *italics* with a double underscore.

To facilitate the timely processing of all applications, please allow 30 days after receipt of your application before calling for a status regarding issuance of your license. Status of license will only be provided personally to the applicant or to ONE individual representative. The applicant must designate the representative in writing as found on the 5th page of the application.

Application Checklist

The Arizona Medical Board (AMB) conducts primary source verification of education, training, hospital affiliations, examination scores and employment; therefore, verification documents must be mailed or faxed ***directly*** to AMB from these entities. All documentation is to be sent to the Arizona Medical Board, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258, **by mail or faxed to 480-551-2704. Please note:** The application will not be considered administratively complete until ***ALL*** documentation has been received from the applicant and the primary source verifying entities.

PLEASE RETURN THIS CHECKLIST WITH YOUR APPLICATION

Applicant's Name: _____

☐ **Applicant will be using FCVS** (Federation Credentials Verification Service) Yes _____ No _____

The following items are to be completed and submitted to the AMB by the applicant.

- ☐ Arizona Allopathic (MD) License Application.
- ☐ Home Address, Phone Number, Social Security Number Supplement and Date of Birth (as per Arizona Revised Statute, your residential address and telephone number are confidential unless they are the only address and phone number of record. Your Social Security Number and Date of Birth are confidential information).
- ☐ Check, Money Order or Payment Card authorization form (see attached) for the nonrefundable application processing fee in the amount of **$500 (US dollars only).** Applications submitted without the fee will not be processed. This is your application fee. Should your application be approved, you will be **invoiced for a prorated licensing fee** depending on your birth month and year.
- ☐ Supplemental form: Complete List of All Hospital, Clinic and/or Medical Employment for the Past Five (5) Years.
- ☐ Malpractice Addendum (if applicable).
- ☐ Copy of evidence of name and date of birth - Submit one of the following**:**
  Birth Certificate, Passport, Baptismal Certificate, Alien Registration Card, Naturalization Certificate.
- ☐ Copy of evidence of any legal name change – submit one of the following, if applicable:
  Marriage License, Official Name Change through the Court.
- ☐ Survey form (Voluntary).

The APPLICANT must forward the following enclosed forms to the appropriate entity for completion. (If applicable)
(Once completed by the entity, these forms are to be sent directly to the AMB.)

- ☐ **Form 2** *Medical College Certification* (If more than one Medical College, forward Form 2 to all Colleges attended.)
- ☐ **Form 3** *Postgraduate Training Certification* **(all programs/completed or not) (Fifth Pathway applicants, please use Form 3)**
- ☐ **Form 5** Verification of ***all*** medical employment for the past five (5) years.
- ☐ **Form 6** Verification of ***all*** hospital affiliations/clinics for the past five (5) years.
- ☐ **Form 7** Clinical Instructor Certification (if using this method to qualify for licensure).
- ☐ **Form 8** *ECFMG Certification* **(*Required for Foreign Medical School Graduates only*)**
  (form available at http://www.ecfmg.org click on "CVS"– State Board on-line or send ECFMG the form supplied in application).

The applicant must request the applicable *license examination results* be sent directly to the AMB.

- ☐ Examination and Board Action History Report (EBAHR) to obtain scores ***only*** for:
  ☐ **USMLE** ☐ **FLEX** ☐ **SPEX** (2 page form available at http://www.fsmb.org click on "Transcript Requests" or choose the on-line form)
- ☐ Endorsement of National Board of Medical Examiners (NBME) certification (form available on line at http://www.nbme.org click on "NBME Certification & Transcripts) or call the Examinee Records Office at 215-590-9592.
- ☐ Licentiate of the Medical Council of Canada (LMCC)
- ☐ Specific State written exam score (Puerto Rico written exam is not accepted)

Note: If it has been more than ten (10) years since the successful passage of a written examination or combination of examinations, the applicant must be certified with the American Board of Medical Specialties (ABMS) or take and pass the Special Purpose Examination (SPEX) to qualify for licensure.

- ☐ If licensed in Puerto Rico or Canada, please request license verification be sent directly to the AMB.

The following required information will be obtained by the AMB:

- ☐ Federation of State Medical Boards (FSMB) Disciplinary Search
- ☐ American Medical Association (AMA) Physician Profile
- ☐ Verification of licensure from every state in which the you currently hold or have ever held a license
- ☐ Verification of ABMS Certification if applying through Endorsement and current ABMS certification
- ☐ National Practitioners Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDP) reports

APPLICATION

Official Use Only: **Inquiry # _____** **Date Application Received _____**

(To be completed and signed by applicant. All questions MUST be answered, even if only to indicate "None" or "N/A".)

1. Present Name_____
(Last) (First) (Middle) (Maiden)

(a) Other names used:_____

2. Office/Training Address:_____
(No.) (Street) (City) (State) (Zip/Post Code)

3. All States or provinces in which you **have or had** a license or registration. If more than five, attach separate listing. If license is pending or was not issued, so state. If none, please indicate by stating "Not Applicable."

(a)_____
(State Board) (License No.)(Status of License, i.e., expired, active, etc.)

(b)_____
(State Board) (License No.)(Status of License, i.e., expired, active, etc.)

(c)_____
(State Board) (License No.)(Status of License, i.e., expired, active, etc.)

(d)_____
(State Board) (License No.)(Status of License, i.e., expired, active, etc.)

(e)_____
(State Board) (License No.)(Status of License, i.e., expired, active, etc.)

4. Medical School Name: _____

Medical School Location: _____ Date of Graduation: _____
Month/Day/Year

If you graduated from a medical school located outside the United States of America or Canada please list below:

ECFMG #_____ Certificate Date: _____
Month/Day/Year

5. List chronologically, all Internship, Residency and Fellowship training in U.S. or Canada **(COMPLETED OR NOT),** or Assistant Professorship (or higher) at any programs attended, showing institution, address, type of program and dates. Attach separate listing if needed.

INSTITUTION NAME	**CITY/STATE**	**TYPE OF PROGRAM/PGY YEAR**	**DATES OF ATTENDANCE**

6. License Exam: Please indicate all exams taken, the date(s) taken (month/day/year) and what state, if applicable:

   a. United States Medical Licensing Exam (USMLE)

   _____ _____ _____ _____

   Step I (Date) Step II (Date) Step III (Date) State

   b. State Written Examination Date _____ State _____
   (The Commonwealth of Puerto Rico written examination is not accepted)

   c. National Board of Medical Examiners Examination (NBME) Certification Date _____

   d. Federation of State Medical Boards Licensing Examination (FLEX) Date(s) _____ _____

   Comp I (Date) Comp II (Date)

   e. Licentiate of the Medical Council of Canada (LMCC) Date _____

   f. Special Purpose Examination (SPEX) Date _____ State _____

7. Indicate your area of practice: _____

   _____

8. List all certifications and re-certifications by a board or sub-board recognized by the **American Board of Medical Specialties only**.

Specialty Board	Certification #	Dates of Certification/Recertification	Expiration Date

9. Account for, in **chronological order,** all activities since graduation from medical school to present. **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR. Attach a separate sheet if necessary. DO NOT ATTACH A CURRICULUM VITA (CV).**

ACTIVITIES	LOCATION	FROM/TO (MONTH/YEAR)
(e.g.) Prepare for USMLE/Vacation	City/State	06/99 to 01/00

10. Have you ever had any application for any professional license refused or denied by any licensing authority?	**YES ☐**	**NO ☐**
11. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?	**YES ☐**	**NO ☐**
12. Have you ever been dropped, suspended, placed on probation, expelled, fined, resigned or been requested to resign from any medical school or post secondary educational program in which you were enrolled?	**YES ☐**	**NO ☐**
13. Has any training program taken action against you including probation, restriction, suspension, revocation, modification, accepted resignation, asked you to leave temporarily or permanently?	**YES ☐**	**NO ☐**
14. Have you ever voluntarily surrendered any healthcare license?	**YES ☐**	**NO ☐**
15. Have you ever had any healthcare license revoked?	**YES ☐**	**NO ☐**
16. Have you ever been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license, been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	**YES ☐**	**NO ☐**
17. Have your privileges ever been restricted, terminated, voluntarily or involuntarily resigned or withdrawn by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	**YES ☐**	**NO ☐**
18. Has disciplinary action been taken against you by any licensing agency with regard to any professional license? Including but not limited to restricted, terminated, voluntarily or involuntarily resigned or withdrawn.	**YES ☐**	**NO ☐**
19. Are there any pending complaints, investigations, or disciplinary actions against you with any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?.	**YES ☐**	**NO ☐**
20. Have you ever had a registration issued by a controlled substance authority (State or Federal) revoked, suspended, limited, restricted, modified, denied or have you surrendered or given up in lieu of action?	**YES ☐**	**NO ☐**
21. Have you ever been charged with or convicted, pardoned or had a record expunged or vacated of a felony, misdemeanor involving moral turpitude? (see explanation below) **A "yes" answer is required even if you entered a diversion program.**	**YES ☐**	**NO ☐**
22. Have you ever been charged with or convicted (including a nolo contendere plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not sentence was imposed or suspended?	**YES ☐**	**NO ☐**
23. In the last ten (10) years has a judgment or settlement been entered against you as a defendant in a medical malpractice suit? ***Please <u>do not</u> report <u>pending</u> malpractice suits or <u>settlements paid not related to a civil action</u>.**	**YES ☐**	**NO ☐**
24. Have you ever been court martialed or discharged other than honorably from the armed service?	**YES ☐**	**NO ☐**
25. Have you ever been terminated from a healthcare position with a city, county, or state government or the Federal government?	**YES ☐**	**NO ☐**
26. Have you ever been convicted of insurance fraud or received sanctions, including restrictions, suspension or removal from practice, imposed by any agency of the Federal government?	**YES ☐**	**NO ☐**

Note: ***<u>In the event the response to any of the questions numbered 10 through 26 is "YES"</u>*****, the applicant must file with the application a detailed report concerning the above matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such charge(s). IN ADDITION, the applicant must submit photocopies of any complaints, hearings, settlements or judgments together with copies of patient's hospital and/or office records to the AMB.**

Moral Turpitude includes but is not limited to the following: Armed Robbery, Assault with a Deadly Weapon, Attempted Insurance Fraud, Fabricating and Presenting False Public Claim, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale & Trafficking in Controlled Substances, Indecent Exposure, Kidnapping, Larceny, Mann Act (Federal Commercialization of Women Statute), Misleading Sale of Securities in Connection with Transfer of Real Property, Perjury, Possession of Heroin for Sale/Unlawful Sale or Dispensing Narcotic Drugs, Rape, Shoplifting and Soliciting Prostitution.

CONFIDENTIAL
Physical/Mental Health and Substance Abuse

1. Within the last five years, have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?	**YES ☐**	**NO ☐**
2. Are you now or have you in the last 5 years been addicted to or abused any chemical substance including alcohol (excluding tobacco and caffeine)?	**YES ☐**	**NO ☐**
3. Are you now being treated or have you in the last 5 years been treated or evaluated for a drug or alcohol addiction or participated in a rehabilitation program? ***If in a confidential program in another state see explanation below.**	**YES ☐**	**NO ☐**
4. Have you ever been criminally charged with or investigated by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility for inappropriate contact with a patient or patients?	**YES ☐**	**NO ☐**
5. Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1) behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice? **See below for definition of ability to practice medicine**.	**YES ☐**	**NO ☐**

***In the event you answer YES to any of the above questions*, you must file with the application a detailed written narrative statement concerning the above matter(s), including the name and address of all training programs or healthcare providers, physicians, preceptors, hospitals/rehabilitation centers, etc. where you were counseled/treated. You must also have a copy of your history and physical examinations, consultation reports, discharge summaries from all hospitals/rehabilitation centers and a statement from your attending physicians or treating therapists setting forth your diagnosis, prognosis and recommendations for continuing care, treatment, supervision and a statement as to whether there is anything that would prevent you from safely practicing any type of medicine. This must be sent directly to the AMB.**

If you are currently participating or have participated pursuant to a CONFIDENTIAL AGREEMENT OR ORDER in a program for the treatment and rehabilitation of doctors of medicine impaired by alcohol, drug abuse or for other issues YOU MUST SUBMIT A NARRATIVE OF CIRCUMSTANCES WITH YOUR APPLICATION AND REQUEST THE FOLLOWING DOCUMENTATION BE SENT DIRECTLY TO THE ARIZONA MEDICAL BOARD'S PHYSICIAN HEALTH PROGRAM.

- **Evaluation/Treatment records**
- **Psychiatric/Psychological records**
- **Compliance reports from state monitoring programs**

Please note: All documents requested above must be sent directly from the primary source to the Arizona Medical Board's Physician Health Program Department from the primary source and will not be accepted if submitted by the applicant.

FAILURE TO PROPERLY ANSWER THESE QUESTIONS OR DISCLOSE ALCOHOL, SUBSTANCE ABUSE OR OTHER ISSUES CAN RESULT IN BOARD DISCIPLINARY ACTION, INCLUDING REVOCATION OR DENIAL OF A LICENSE.

If you have any questions, please contact the Board's Physician Health Program at (480) 551-2716 or (877) 255-2212.

Ability to practice medicine is to be construed to include all of the following:

1. **The cognitive capacity to make appropriate clinical diagnoses and exercise reason medical judgments and to learn and keep abreast of medical developments;**
2. **The ability to communicate those judgments and medical information to patients and other healthcare providers, with or without the use of aids or devices, such as a voice amplifier; and**
3. **The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.**

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to chronic and/or uncorrected orthopedic, visual, speech, or hearing impairments, epilepsy, multiple sclerosis, behavioral health illness, dementia, drug addiction and alcoholism.

The applicant_____

(PRINT OR TYPE YOUR NAME)

being first duly sworn upon his oath deposes and says: that I am the person herein named subscribing to this application; that I have read the statutes and rules regarding licensure and have read the complete application, know the full content thereof, and declare that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which the applicant is aware that the applicant is the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present and future), and all government agencies (local, state, federal or foreign) to release to the Arizona Medical Board or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my medical competence, professional conduct or physical or mental ability to safely engage in the practice of medicine. I further authorize the Arizona Medical Board or its successors to release to the organizations, individuals or groups listed above any information which is material to the application or any subsequent licensure. I further acknowledge that falsification or misrepresentation of any item or response on this application is adequate to deny the same or to hold a hearing to revoke the same, if issued.

Under penalty of perjury I certify I am a U.S. Citizen or a qualified/registered alien.

Signature of Applicant_____, M.D. Date _____

If you would like to designate/authorize ONE other individual beside yourself to check the status of your application with the AMB, please complete the following information:

Entity name:_____ Individual Name_____Phone #_____

*** ARIZONA LAW REQUIRES AN APPLICANT WHO HAS BEEN CHARGED WITH A FELONY OR A MISDEMEANOR INVOLVING CONDUCT THAT MAY AFFECT PATIENT SAFETY AFTER SUBMITTING THE APPLICATION TO NOTIFY THE AMB WITHIN 10 DAYS AFTER THE CHARGE IS FILED. ARIZONA REVISED STATUTE (A.R.S.) §32-3208 (SEE WEBSITE UNDER *Physician Center – Reportable Misdemeanors* FOR LIST OF REPORTABLE MISDEMEANORS – ALL FELONIES ARE REPORTABLE.)**

FOR OFFICIAL USE ONLY

Application Processed by _____

Application Approved _____ 20 _____ by _____

License Issued _____ License Number _____

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700Fax: 480-551-2704
www.azmd.gov

MALPRACTICE ADDENDUM

(Complete this form if you answered YES to question #23 on the application)

The applicant must complete this form for each malpractice settlement or judgment in the last ten (10) years. If more than one case, please make copies of this form and return with required documents. Please report only the settlement of a civil action.

Applicant Name _____, M.D.

1. **On a separate sheet of paper type your full name and provide a <u>detailed clinical narrative</u> regarding each malpractice case(s). Include name of patient, age, sex, date of occurrence and location (include address). Do not omit the answers to these questions or make reference to attached documents for answers. This section must be completed with your <u>own description</u> that includes all of the facts requested above. *NOTE:* HIPAA regulations do not prevent you from responding and providing the requested information.**

2. **Indicate your position in case, i.e., intern, resident, primary doctor, etc.**
   _____

3. **Case was filed against: Individual doctor ☐ Group ☐ Hospital ☐**

4. **What was the amount and date of the judgment or settlement?_____**
   Amount Date

5. **Amount of judgment or settlement attributed to you_____**

6. **Has this case been investigated or reviewed by any State Medical Board?** ☐ Yes ☐ No
   If answer is "Yes", <u>request letter of resolution from State Medical Board be sent directly to us</u>. You do not need to attach the documents listed below if the case has been investigated or reviewed by any State Medical Board.

You are required to attach the following for each case:

- **Copy of plaintiff's complaint**
- **Copy of Judgment or Settlement Agreement**
- **Copy of complete set of medical records including x-rays or diagnostic films**

  *** X-rays and diagnostic films must be included. Your application cannot be processed without them.**

I certify that the information which I have provided is correct to the best of my knowledge.

_____ _____
Signature **Date**

Your application is not administratively complete until all documents are received.

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700 Fax: 480-551-2704
www.azmd.gov

Home Address, Telephone Number, Social Security Number and Date of Birth

(Confidential Information, see below)

Please Read Carefully

RETURN WITH APPLICATION

Arizona Revised Statute (A.R.S.) §32-1435(B) requires the licensee to provide the Arizona Medical Board with a current address and telephone number. Additionally, A.R.S. § 32-3801 mandates that the Arizona Medical Board not provide access to a physician's home address and telephone number unless these are the only address and telephone number of record. Please ***do not*** indicate your home address and telephone number on any other application forms for licensure.

Please type or legibly print the following information:

_____
Name

_____
Home Street Address

_____
City, State, Zip or Postal Code, Country

_____
Home phone number (including area code) Office Phone Number

_____
Home e-mail address Office e-mail address

_____
Home Fax Office Fax

Home address and telephone phone number will remain confidential
unless it is the only address and telephone number of record.

Please send all correspondence to _____Home _____Office

_____
Social Security Number Date of Birth (Month, Day and Year)

_____
City and State or Country of Birth

SOCIAL SECURITY NUMBER, DATE OF BIRTH AND PLACE OF BIRTH ARE CONFIDENTIAL INFORMATION – NOT FOR PUBLIC DISCLOSURE

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700Fax: 480-551-2704
www.azmd.org

Supplemental Form
Hospital Affiliation/Clinic/Medical Employment Listing

INSTRUCTIONS:

1. Please type or print legibly.
2. List all hospital affiliations for the past five (5) years to include moonlighting and courtesy staff affiliations.
3. ***Do not*** include postgraduate training or self employment.
4. List all employment with medical employment, i.e. medical clinic, physician placement group, emergency medical group, radiology group, etc.
5. If none, please indicate N/A. (Do not submit form 5 & 6)

RETURN THIS FORM WITH YOUR APPLICATION

Applicant Name: _____**, M.D.**

HOSPITAL/CLINIC

1. Hospital/Clinic: _____

   Address: _____
   Street City State Zip/Post Code

   Dates of Staff Membership: _____ Type of Staff Membership: _____

2. Hospital/Clinic: _____

   Address: _____
   Street City State Zip/Post Code

   Dates of Staff Membership: _____ Type of Staff Membership: _____

3. Hospital/Clinic: _____

   Address: _____
   Street City State Zip/Post Code

   Dates of Staff Membership: _____ Type of Staff Membership: _____

4. Hospital/Clinic: _____

   Address: _____
   Street City State Zip/Post Code

   Dates of Staff Membership: _____ Type of Staff Membership: _____

MEDICAL EMPLOYMENT

1. Medical Employment:_____

   Address: _____
   Street City State Zip/Post Code

   Dates of Employment: _____

2. Medical Employment:_____

   Address: _____
   Street City State Zip/Post Code

   Dates of Employment: _____

3. Medical Employment:_____

   Address: _____
   Street City State Zip/Post Code

   Dates of Employment: _____

	Arizona Medical Board 9545 East Doubletree Ranch Road Scottsdale, Arizona 85258 Phone: 480-551-2700Fax: 480-551-2704 www.azmd.org	**Form 2** **Medical College Certification**

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by the **Dean or the Registrar** of all medical schools attended. This is your authorization to release any information in your files of record, favorable or otherwise, **DIRECTLY** to the Arizona Medical Board, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258, by mail or fax. Your prompt response will be appreciated.

Applicant Name: ____, M.D.

____

Signature   Date (Month/Day/Year)

= =

(DO NOT DETACH)

This section to be completed by an official of the Medical school.

This certifies that ____

(Name of applicant)

was enrolled in ____

(Name of Medical School)   (Location – City/State)

The undersigned further certifies that the records of this institution show that the applicant attended this institution

from ______________________________to______________________________

(month/year)   (month/year)

Please check one: _____________ The applicant was granted a medical degree by

_____________ The applicant withdrew from

the above named Medical School on ______________________________.

(month /day /year)

Advanced credits – Credits granted upon admission

__________________________ __________________________ __________________________

(name of medical school)   (total credits)   (dates attended)

(SEAL OF COLLEGE)

(If no seal, please indicate)

Signed: ____

Name Typed or Printed: __________________________________

Title: ____ Date ______________________________

Address:____

Telephone number: __________________________________ Fax number: __________________________________

	Arizona Medical Board 9545 East Doubletree Ranch Road Scottsdale, Arizona 85258 Phone: 480-551-2700Fax: 480-551-2704 www.azmd.org	**Form 3** **Postgraduate Training Certification**

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by the **Program Director** of each postgraduate training program in the United States, its territories, and/or Canada that I participated in. This is your authorization to release any information in your files of record, favorable or otherwise, **DIRECTLY** to the Arizona Medical Board, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258, by mail or fax. Your prompt response will be appreciated.

Applicant Name: ____, M.D.

____

Signature Date (Month/Day/Year)

= =

(DO NOT DETACH)

Important – Program Participation: Report incomplete postgraduate years (PGY) separately from those that were successfully completed. If the postgraduate year is currently in progress, report the expected completion in the "To" field. Report internships, residencies and fellowships separately.

PG/Year:________ DEPARTMENT/SPECIALTY:____
________Internship
________Residency From:_________/________/_________ To:___________/___________/__________
________Fellowship
________Research Successfully completed? _______ Yes _________No ________ In Progress

PG/Year:________ DEPARTMENT/SPECIALTY:____
________Internship
________Residency From:_________/________/_________ To:___________/___________/__________
________Fellowship
________Research Successfully completed? _______ Yes _________No ________ In Progress

PG/Year:________ DEPARTMENT/SPECIALTY:____
________Internship
________Residency From:_________/________/_________ To:___________/___________/__________
________Fellowship
________Research Successfully completed? _______ Yes _________No ________ In Progress

Circle the correct response to the question below:
Is this training approved by the Accreditation Council for Graduate Medical Education (ACGME)? **Yes** **No**

Circle the correct response to the questions below: ("Yes" responses require written explanation.)
Did this individual ever take a leave of absence or break from their training? **Yes** **No**

Was this individual disciplined and/or placed under investigation or on probation? **Yes** **No**

Please explain below any "Yes" responses(s) to the above two questions. If necessary, you may continue your explanation on a separate sheet of paper.

____

____

____

Signed: ____ (SEAL OF TRAINING PROGRAM)

Name Typed or Printed: ________________________________ (If no seal, please indicate)

Title: ____ Date ______________________________

Full name of Hospital or Program____

Address: ____

Telephone number: ________________________________ Fax number: ______________________________

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700Fax: 480-551-2704
www.azmd.org

Form 5
Medical Employment Verification

In applying for a license to practice medicine in Arizona, the Arizona Medical Board requires this form to be completed by the **Medical Employer** where I have been employed for evaluation of my professional record, mental and physical capabilities during the five years preceding my application. This is authorization to release any information in your files of record, favorable or otherwise, ***DIRECTLY*** to the ARIZONA MEDICAL BOARD, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258, by mail or fax.

Applicant Name: ____, M.D.

____
Signature Date (Month/Day/Year)

= =

(DO NOT DETACH)

This is to certify that ____________________________________, M.D.,

held/holds the following position: ____________________________________

Dates: From**:** ____________________ To: ____________________
Month/Day/Year Month/Day/Year

Comments, if any**:**____

____

____

____

____

____

____

Employer: ____

Address ____
Number and Street City State Zip

Signature**:** ______________________________ Title: ____________________

______________________________ Date: ____________________
(Name/Typed or Printed)

Telephone Number: ______________________________

Fax Number: ______________________________

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700Fax: 480-551-2704
www.azmd.org

Form 6
Hospital/Clinic Affiliation Verification

In applying for a license to practice medicine in Arizona, the Arizona Medical Board requires this form to be completed by the **Medical Director or Chief of Medical Staff** where I have held privileges, consultation or teaching appointments for evaluation of my professional record, mental and physical capabilities, during the five years preceding my application. This is authorization to release any information in your files of record, favorable or otherwise, ***DIRECTLY*** to the ARIZONA MEDICAL BOARD, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258, by mail or fax.

Applicant Name: ______________________________, M.D.

____
Signature   Date (Month/Day/Year)

= =

(DO NOT DETACH)

This is to certify that ______________________________, M.D.,

was/is extended the following privileges: ______________________________

1. Dates: From: ____________________ To: ____________________
Month/Day/Year   Month/Day/Year

2. Have staff privileges ever been limited, restricted, suspended, revoked or equivalent? Yes _____ No _____
If **YES**, please explain below or attach written explanation.

3. Is/was Physician in Good Standing? Yes _____ No _____ If **NO**, please attach written explanation**.**

4. Names of other hospital affiliations, if known (list name, city, and state):

   1. ______________________________
   2. ______________________________
   3. ______________________________
   4. ______________________________

Comments, if any: ______________________________

____

____

____

Hospital/Clinic Name ______________________________

Address ______________________________
Number and Street   City   State   Zip

Signature**:** ______________________________ Title: ____________________

______________________________ Date: ____________________
(Name/Typed or Printed)

STAMP OR SEAL OF HOSPITAL
(If no seal, please indicate)

Telephone Number____________________

Fax Number ____________________

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Phone: 480-551-2700Fax: 480-551-2704
www.azmd.gov

Form 7
Clinical Instructor Certification

In applying for a license to practice medicine in Arizona, the Arizona Medical Board requires this form to be completed by **Program Director** of the hospital wherein I have been employed as a full-time Clinical Instructor ranked Assistant Professor or higher in an accredited postgraduate medical education program in the United States or Canada. This is authorization to release any information in your files of record, favorable or otherwise, ***DIRECTLY*** to the ARIZONA MEDICAL BOARD, 9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258, by mail or fax.

Applicant Name: ____, M.D.

______________________________ ______________________________
Signature Date (Month/Day/Year)

= =

(DO NOT DETACH)

This section to be completed by the Program Director of the accredited postgraduate medical education wherein the applicant has been or is employed as a Full-time Clinical Instructor ranked Assistant Professor or higher in the United States or Canada.

This is to certify that ____ M.D. is/was a full-time
(Full name of applicant)

______________________________ in the ______________________________at
(Rank, i.e. Assistant Professor, etc.) (Type of Program)

____
(Full Name and Address of Medical School Hospital)

____

in the field of ______________________ from ______________________to ______________________
(Date-Month/Day/Year) (Date-Month/Day/Year)

1. The said program was approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada. Yes _____ No _____
2. Have applicant's hospital or teaching duties ever been restricted or limited? Yes _____ No _____ If **YES**, please attach written explanation.
3. Was applicant granted full clinical privileges at your institution? Yes _____ No _____ If **NO**, please attach written explanation.
4. Was there any reason not to continue applicant as an instructor? Yes _____ No _____ If **YES**, please attach written explanation.
5. Was applicant's performance as an instructor consistently rated satisfactory and/or above? Yes _____ No _____ If **NO**, please attach written explanation and a copy of the evaluation(s).

(Seal of Hospital)

Signed: ____

Title: ____

Address: ____

Date: ______________________Telephone number: ______________________ Fax number: ______________________

REQUEST FOR STATUS REPORT OF ECFMG® CERTIFICATION

Reports will be sent directly to the STATE MEDICAL BOARD.

To confirm ECFMG certification status for an international medical graduate, please complete and return this form to:

ECFMG *Certification Verification Service*
PO Box 48083
Newark, NJ 07101-4883

Please type or print.
Requests with incomplete or inaccurate information will not be processed.

USMLE™/ECFMG Identification Number: 0 - ☐☐☐-☐☐☐-☐

Physician's Name: _____ _____ _____
First Middle Last Name/Surname/Family Name

Date of Birth:_____ / _____ / _____
Day Month Year

Name of State Medical Board that Status Report should be sent to:

Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258

State Board Contact: Suzann Grabe, Licensing Office Manager 480-551-2756

☐ **Payment Form 900 is enclosed.**

Checks should be made payable to ECFMG in U.S. dollars. Status Reports will be mailed directly to the State Medical Board indicated above. Requests without payment attached will not be processed.

Note: Requesting organizations must normally secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the ECFMG certification information or make it available to any party beyond this request as authorized by the physician. The information may only be used to confirm ECFMG Certification for the purpose for which the physician provided authorization.

Physicians who are ECFMG certified have passed the requisite examinations and have had their medical education credentials verified by ECFMG. ECFMG Certification is a prerequisite for entry into ACGME-accredited residency or fellowship programs in the United States; is required for licensure to practice medicine in the United States; and is one of the eligibility requirements to take USMLE Step 3.

EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

BY MAIL: ECFMG, PO Box 48083, Newark, NJ 07101-4887 USA
BY COURIER: ECFMG, c/o Image Remit, 205 North Center Drive, Commerce Center, North Brunswick, NJ 08902 USA
TELEPHONE: 215-386-5900 • **FAX:** 215-386-3185 • **INTERNET:** www.ecfmg.org

PAYMENT

Payment For Service(s) Requested ☐

1

Enter your Identification Number.

Enter your name.

USMLE™ / ECFMG® Identification Number: ☐-☐☐☐-☐☐☐-☐

First Name(s):

Middle Name(s):

Last Name (Surname or Family Name):

2

Indicate the service(s) for which you are providing payment.

- ☐ Extension of USMLE Step 1 / Step 2 CK Eligibility Period ($50 per exam)
- ☐ ERAS® Token ($75) – ERAS Applicants: Do NOT use this form to pay for transmission of your USMLE transcript via ERAS. Instead, logon to www.myeras.aamc.org.
- ☐ USMLE Transcript ($50 per request form – up to ten transcripts)
- ☐ ECFMG Exam Chart ($50 per request form – up to three copies)
- ☐ ECFMG CSA History Chart ($50 per request form – up to ten copies)
- ☐ CVS – State Board ($25)
- ☐ EVSP (J-1 VISA) ($200)
- ☐ Score Recheck: USMLE Step 1/Step 2 CK/Step 2 CS ($55 per exam)
- ☐ Duplicate Certificate ($25)
- ☐ Name Change on ECFMG Certificate ($25)
- ☐ File Copy Fee ($25)
- ☐ Translation Fee – Medical School Transcript ($160)
- ☐ Previous Balance/Other (Specify): $ _____

3

Select a method of payment and complete all information requested.

Do **NOT** send cash.

(A) ☐ **Charge my credit card.**

Credit Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ **Exp. Date (Month/Year):** ☐☐/☐☐☐☐

Check One: ☐ **VISA** ☐ **MASTERCARD** ☐ **DISCOVER**

Name of Card Holder:

Address of Card Holder:

City:

State:

Country:

Zip/Postal Code:

By signing below, I authorize ECFMG to charge my credit card in the amount indicated above.

Signature of Card Holder:

(B) ☐ **My check, bank draft, or money order made payable to ECFMG is enclosed.**

Payment must be made in U.S. funds through a U.S. bank.
Include your USMLE/ECFMG Identification Number on your check.

(C) ☐ **I have sent a wire transfer to ECFMG.**

Funds may be wire transferred through most banks in the United States (Fedwire) to the ECFMG ACCOUNT NUMBER 361024284 at COMMERCE BANK, ROUTING / TRANSIT NUMBER 036001808. Your payment must be identified with your full name and USMLE / ECFMG Identification Number. Additionally, you must provide the following information:

Date Sent:

Originating Bank:

Bank Reference Number:

Name of Sender:

ECFMG Payment Policy

If you owe money to ECFMG at the time that your request is processed, ECFMG will apply the payment included with your request to the amount that you owe. Any money that is left after this will be used to pay for the service(s) that you request. If there is not enough money remaining to pay for the service(s) you request, your request will not be processed. If you have money in your ECFMG account at the time that your request is processed, it will be used to pay for the next request for service processed by ECFMG. If you have money in your ECFMG account and will not request additional exams / services, you may send a written request to ECFMG for a refund. Refer to "Payment" in the ECFMG *Information Booklet* for detailed information on ECFMG's Payment Policy.

ARIZONA MEDICAL BOARD

Please complete the survey below and return with your application for licensure.

(This is a voluntary survey. You are not required to complete this survey for your application to processed.)

Applicant Name _____, M.D.

1. I am applying for an Arizona license because: (select the three most important reasons from the "Reason for Applying for an Arizona License"- see box)

_____ _____ _____
Reason #1 Reason #2 Reason #3

REASON FOR APPLYING FOR AN ARIZONA LICENSE
1. Completed a residency.
2. Considering retirement.
3. Bought into practice/became partner.
4. Opportunity to serve an underserved group.
5. Malpractice expenses too high in current practice state.
6. Position ended.
7. Too much paperwork.
8. To change the scope of practice.

2. Please indicate which of the following was important in influencing you to practice in Arizona. Circle **one** code number after each factor.

Factor	Important	Not Important	Does Not Apply
1. Grew up in the area	1	2	3
2. Personal ties in the community	1	2	3
3. Professional contacts	1	2	3
4. Characteristic of the community	1	2	3
5. Financial advantages	1	2	3
6. The opportunity to serve a particular group of people	1	2	3
7. Best professional opportunity available	1	2	3
8. Recruited by colleagues	1	2	3
9. Availability of adequate hospital facilities	1	2	3
10. Influence of Spouse	1	2	3
11. Location of military service	1	2	3
12. Location of residency	1	2	3
13. Earnings potential	1	2	3
14. Work environment/hours of work	1	2	3

15. If other important factor, specify_____
_____
_____

3. Please list the code number from the list above which represents the SINGLE most important reason that influenced you to practice in Arizona. _____

4. I am moving **to** (city/town)_____ Arizona **from** (city/town)_____ (state/country)_____

ARIZONA MEDICAL BOARD

PAYMENT CARD AUTHORIZATION
ALLOPATHIC LICENSURE APPLICATION PROCESSING FEE

Payment for: _____,M.D.

APPLICATION PROCESSING FEE $500

Type of Card: ☐ **Visa** ☐ **MasterCard**

Card #: ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐

Expiration Date: ☐☐ - ☐☐ **(MM-YY)**

Name as Shown on Payment Card: _____

Billing Address: (Required**)**

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number of Cardholder: (Required**)** _____

Mailing Address: (If different from billing address)

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Signature of Cardholder: _____ **Date**:_____

Please complete and return this form *with your application and all necessary documents for licensure* if paying by credit card.
This form and the application may be faxed to: 480-551-2704

If faxing this form, please do not mail the original as you may be charged twice.
OR
You may mail the form and application to: Arizona Medical Board, 9545 E. Doubletree Ranch Road. Scottsdale, AZ 85258

ARIZONA REVISED STATUTES/REQUIREMENTS FOR ALLOPATHIC LICENSURE

32-1422. Basic requirements for granting a license to practice medicine

A. An applicant for a license to practice medicine in this state pursuant to this article shall meet each of the following basic requirements:

1. Graduate from an approved school of medicine or receive a medical education which the board deems to be of equivalent quality.

2. Successfully complete an approved twelve month hospital internship, residency or clinical fellowship program.

3. Have the physical and mental capability to safely engage in the practice of medicine.

4. Have a professional record which indicates that the applicant has not committed any act or engaged in any conduct which would constitute grounds for disciplinary action against a licensee under this chapter.

5. Has not had a license to practice medicine revoked by a medical regulatory board in another jurisdiction in the United States for an act that occurred in that jurisdiction that constitutes unprofessional conduct pursuant to this chapter.

6. Is not currently under investigation, suspension or restriction by a medical regulatory board in another jurisdiction in the United States for an act that occurred in that jurisdiction that constitutes unprofessional conduct pursuant to this chapter. If the applicant is under investigation by a medical regulatory board in another jurisdiction, the board shall suspend the application process and may not issue or deny a license to the applicant until the investigation is resolved.

7. Has not surrendered, relinquished or given up a license to practice medicine in lieu of disciplinary action by a medical regulatory board in another jurisdiction in the United States for an act that occurred in that jurisdiction that constitutes unprofessional conduct pursuant to this chapter.

8. Pay all fees required by the board.

9. Complete the application as required by the board.

B. The board may require the submission of such credentials or other evidence, written and oral, and make any investigation it deems necessary to adequately inform itself with respect to an applicant's ability to meet the requirements prescribed by this section, including a requirement that the applicant for licensure undergo a physical examination, a mental evaluation and an oral competence examination and interview, or any combination thereof, as the board deems proper.

C. In determining if the requirements of subsection A, paragraph 4 have been met, if the board finds that the applicant committed an act or engaged in conduct that would constitute grounds for disciplinary action, the board shall determine to its satisfaction that the conduct has been corrected, monitored and resolved. If the matter has not been resolved, the board shall determine to its satisfaction that mitigating circumstances exist which prevent its resolution.

D. In determining if the requirements of subsection A, paragraph 6, have been met, if another jurisdiction has taken disciplinary action against an applicant, the board shall determine to its satisfaction that the cause for the action was corrected and the matter resolved. If the matter has not been resolved by that jurisdiction, the board shall determine to its satisfaction that mitigating circumstances exist which prevent its resolution.

E. The board may delegate authority to the executive director to deny licenses if applicants do not meet the requirements of this section.

32-1423. Additional requirements for students graduating from an unapproved allopathic school of medicine

In addition to the basic requirements for licensure prescribed in section 32-1422, any applicant who has graduated from an unapproved school of medicine shall meet each of the following requirements:

1. Be able to read, write, speak, understand and be understood in the English language.

2. Hold a standard certificate issued by the educational council for foreign medical graduates, complete a fifth pathway program as provided in section 32-1424, subsection A, or complete thirty-six months as a full-time assistant professor or in a higher position in an approved school of medicine.

3. Successfully complete an approved twenty-four month hospital internship, residency or clinical fellowship program, in addition to the twelve months required in section 32-1422, subsection A, paragraph 2, for a total of thirty-six months of training unless the applicant successfully completed a fifth pathway program as provided by section 32-1424 or has served as a full-time assistant professor or in a higher position in an approved school of medicine for a total of thirty-six months.

32-1424. Fifth pathway program; licensure

A. In addition to the requirements for licensure prescribed in sections 32-1422 and 32-1423, an applicant for licensure under this article who attended a foreign school of medicine and successfully completed all the formal requirements to receive the degree of doctor of medicine except internship or social service, and is accordingly not eligible for certification by the educational council for foreign medical graduates, may be considered for licensure under this chapter if the applicant meets the following conditions:

1. Satisfactorily completes an approved fifth pathway program of one academic year of supervised clinical training under the direction of an approved school of medicine in the United States.

2. Successfully completes an approved twenty-four month internship, residency or clinical fellowship program upon completion of the fifth pathway program.

B. A document granted by a foreign school of medicine signifying completion of all the formal requirements for graduation from such foreign medical school except internship or social service training, or both, along with certification by the approved school of medicine in the United States of successful completion of the fifth pathway program is deemed the equivalent of a degree of doctor of medicine for purposes of licensure and practice as a physician in this state.

32-1425. Initial Licensure

A. An applicant who meets the applicable requirements provided in section 32-1422, 32-1423 or 32-1424, has passed steps one and two of the United States medical licensing examination or one of the examination combinations prescribed in section 32-1426, subsection A, paragraph 6, subdivision (c), items (i) and (ii), has paid the fees required by this chapter and has filed a completed application found by the board to be true and correct is eligible for licensure as a doctor of medicine upon successful passage of step three of the United States medical licensing examination with a scaled score of at least seventy-five if the applicant has passed all three steps within a seven year period.

B. An applicant for licensure applying pursuant to section 32-1422, 32-1423 or 32-1424 may take the examination only after successfully completing six months of a board approved hospital internship, residency or clinical fellowship or fifth pathway program or serving as a full-time assistant professor or in a higher position in a board approved school of medicine in this state.

C. The board shall not grant a license until the applicant meets the requirements for licensure pursuant to this chapter.

32-1426. Licensure by endorsement

A. An applicant who is licensed in another jurisdiction and who meets the applicable requirements prescribed in section 32-1422, 32-1423 or 32-1424, has paid the fees required by this chapter and has filed a completed application found by the board to be true and correct is eligible to be licensed to engage in the practice of medicine in this state through endorsement under any one of the following conditions:

1. The applicant is certified by the national board of medical examiners or its successor entity as having successfully passed all three parts of the United States medical licensing examination or its successor examination.

2. The applicant has successfully passed a written examination that the board determines is equivalent to the United States medical licensing examination and that is administered by any state, territory or district of the United States, a province of Canada or the medical council of Canada.

3. The applicant successfully completed the three part written federation of state medical boards licensing examination administered by any jurisdiction before January 1, 1985 and obtained a weighted grade average of at least seventy-five on the complete examination. Successful completion of the examination shall be achieved in one sitting.

4. The applicant successfully completed the two component federation licensing examination administered after December 1, 1984 and obtained a scaled score of at least seventy-five on each component within a five year period.

5. The applicant's score on the United States medical licensing examination was equal to the score required by this state for licensure pursuant to section 32-1425.

6. The applicant successfully completed one of the following combinations of examinations:

(a) Parts one and two of the national board of medical examiners examination, administered either by the national board of medical examiners or the educational commission for foreign medical graduates, with a successful score determined by the national board of medical examiners and passed either step three of the United States medical licensing examination or component two of the federation licensing examination with a scaled score of at least seventy-five.

(b) The federation licensing examination component one examination and the United States medical licensing step three examination with scaled scores of at least seventy-five.

(c) Each of the following:

(i) Part one of the national board of medical examiners licensing examination with a passing grade as determined by the national board of medical examiners or step one of the United States medical licensing examination with a scaled score of at least seventy-five.

(ii) Part two of the national board of medical examiners licensing examination with a passing grade as determined by the national board of medical examiners or step two of the United States medical licensing examination with a scaled score of at least seventy-five.

(iii) Part three of the national board of medical examiners licensing examination with a passing grade as determined by the national board of medical examiners or step three of the United States medical licensing examination with a scaled score of at least seventy-five or component two of the federation licensing examination with a scaled score of at least seventy-five.

B. The board may require an applicant seeking licensure by endorsement based on successful passage of a written examination or combination of examinations, the most recent of which precedes by more than ten years the application for licensure by endorsement in this state to take and pass a special purpose licensing examination to assist the board in determining the applicant's ability to safely engage in the practice of medicine. The board may also conduct a records review and physical and psychological assessments. If appropriate, and may review practice history to determine the applicant’s ability to safely engage in the practice of medicine.